Testimony of the Connecticut State Medical Society
House Bill 5447
An Act Concerning Prior Authorization for Health Care Provider Services

Insurance and Real Estate Committee
March 17, 2022

Senator Lesser, Representative Wood and distinguished members of the Insurance and Real Estate Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS), thank you for the opportunity to provide testimony on **House Bill 5447, An Act Concerning Prior Authorization for Health Care Provider Services.**

CSMS would like to thank this Committee for introducing legislation that addresses health plan prior authorization requirements. Almost universally, our members cite prior authorization burdens as the number one issue facing their practice. The health plan prior authorization process impacts the ability of patients to receive timely, needed medical care and requires physicians and their office staff to spend needless hours each week trying to obtain medically necessary care for their patients.

Prior Authorization: The Problem

Prior authorization is an administrative hurdle created by the health insurance industry to commonly delay access to care for patients and serve as an imposition into the patient-physician relationship and decision-making process. Prior authorization processes can harm patient outcomes and create a tremendous obstacle to treatment decisions deemed most appropriate by physicians.

The concept of prior authorization originated from the use of utilization reviews in the 1960s. Utilization review started at the beginning of Medicare and Medicaid legislation and the primary use was to verify an admission to a hospital in an attempt to limit unnecessary hospital stays and cut costs. As managed care took hold throughout the 1990s, health insurers used prior authorization, but rather sparingly and only when it came to high-cost pharmaceuticals and high-cost services. In the last three decades, however, the use of prior authorization has snowballed, and we have reached a point where health plans require prior authorization for a multitude of procedures, tests, surgeries, and pharmaceuticals. Where prior authorization began as a reason to look at hospital admissions, we now see it being used as a blunt edged tool designed to reduce reimbursement for medical care.

Ultimately, almost all services requiring prior authorization are approved. Thus, these prior authorization requirements are unnecessary, detrimental to patient health, and wasteful of the physician's time and resources. Prior authorization requirements (even for services that are ultimately approved) invariably delay care and keep physicians on the phone with health plans, detracting from time that could be spent on patient care.

Additionally, before a health plan can issue an adverse determination on a prior authorization request, the health plan is supposed to provide the physician whose service is being reviewed a reasonable opportunity to discuss the proposed care with the reviewing physician. This is sometimes informally referred to as a "peer-to-peer" call. Often the reviewing "peer" physician is not of the same specialty as the treating physician. For example, an oncologist's recommended course of treatment could be reviewed by an orthopedic surgeon working for the health plan. Due to the difference in specialty areas, the "peer" physician may not be as familiar with the course of treatment being reviewed. This specialty difference can lead to unnecessary initial denials of prior authorization requests and delays in medically necessary care.

Aside from the delays in patient care and the burdens faced by physicians, health plans commonly use medical necessity criteria and other clinical guidelines for prior authorization processes, guidelines that are often deemed proprietary and not shared with physicians. In addition, each health plan has a different and ever-changing list of what services that require prior authorization. There is no uniformity between the commercial health plans, as well as Medicare and Medicaid. This makes it nearly impossible for physicians to keep track of what services require prior authorization as well as how to anticipate what the health plan may request as evidence of medical necessity. As a result of this lack of transparency, there is often extensive back and forth between physicians and health plans in response to insurer requests for documentation. It is crucial for patient safety that payers are transparent so that physicians can resubmit for approval as quickly as possible to avoid any delays in care or treatment for patients.

In addition, health plans have multiple departments internally that deal with prior authorizations. Physicians may encounter one department or representative of the plan who will state that prior authorization is not needed and then after the service is provided to the patient, another department of that same health plan will now deny the service saying that prior authorization was in fact needed. This results in both the patient and/or the physician being responsible for the financial cost of the service not through any fault of their own, but solely due to the failure of the health plan to coordinate its own internal departments. This logic is backwards, counterproductive, and destructive to the patient-physician relationship. Errors and inefficiencies of health plans should not be used to punish either patients or physicians. Health plans should be held responsible for their initial determinations.

In a 2021 survey of physicians conducted by the American Medical Association (AMA), 93% of respondents reported that prior authorization requirements created delays in accessing necessary care. In that survey, 82% of physicians reported that prior authorization can lead to patients abandoning a recommended course of treatment. In addition, 34% of respondents reported that prior authorization requirements have led to a serious adverse medical event for a patient with nearly one quarter reporting that prior authorization delays have led to a patient's hospitalization.

Prior authorization requirements delay patients timely access to health care. Every physician has a story about a patient that was harmed by a prior authorization delay; some with very tragic endings. In the orthopedic setting, it is not uncommon for a health plan to deny a patient a needed MRI, instead requiring several sessions of physical therapy be done first before the MRI is approved. The physician knows the physical therapy will not help the patient and the patient is forced to spend time and money on an often-futile exercise simply to "check the box" that is required by the health plan to get the MRI. As this Committee and the General Assembly look to ways to decrease health care expenditures, how does a process that requires a useless medical spend fit within the cost containment objectives?

Prior Authorization: The Solution

Last year, the Texas legislature passed the Gold Card Law which allows physicians who have a 90 percent prior authorization approval rate over a six-month period on certain services to be exempt, or "gold carded", from prior authorization requirements for those services. The idea behind gold card legislation is that physicians who routinely receive prior authorization approvals for services will be able to bypass the prior authorization approval process, allowing patients more timely access to needed medical care and eliminating a significant administrative burden for the physician.

CSMS is supportive of similar "gold card" legislation for Connecticut. Gold carding is included in a set of prior authorization reform principles put forth by the AMA and 16 other physician, patient, and health care organizations. Specifically, these principles state that health plans should restrict utilization management programs to outlier providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors. The principles further elaborate that health plans should offer a physician-driven, clinically based alternative to prior authorization, such as gold card programs.

In addition to gold carding, CSMS advocates for a uniform set of standards that must be used by all commercial health plans. As noted above, it is nearly impossible for a physician office to keep track of the myriad of requirements, methodologies, and documentation necessities when each of the commercial health plans, as well as Medicaid and Medicare, has a different set of standards.

Lastly, in a world dominated by technology, it seems incredibly obsolete that health carriers require prior authorization to be done primarily by telephone and facsimile. Physicians can spend hours on the phone trying to get a representative of the health plan on the phone to discuss a prior authorization request. Follow-up information is often required to be sent via facsimile and often necessitates further phone calls to ensure information was received. It is astounding that the prior authorization process is not automated or done through electronic means.

Prior Authorization: The Impact on Connecticut

It is no secret to this Committee and the General Assembly that the independent practice of medicine is disappearing. The Physician's Advocacy Institute (PAI) will be releasing a study next

week showing the alarming growth in the Northeast of hospital-based employment and the proliferation of private-equity physician practice ownership. These trends have been drastically accelerated by the Covid-19 pandemic. There is currently a workgroup convened by the Office of Health Strategy to look at physician practice mergers and the independent practice of medicine. However, it is not news to Connecticut's physicians that administrative burdens created by the health plans, such as prior authorization are a big factor in driving consolidation and ultimately the demise of the independent practice of medicine. The time to do something about prior authorizations is now. The reality is that Connecticut physicians and patients cannot wait even one more year for relief. We do not need a study; we need a solution. The time has come to fix prior authorization in Connecticut and help preserve what is left of the independent practice of medicine. Our patients need help. Our physicians need help. CSMS stands ready to work with this Committee on implementing a solution this session to fix prior authorization.